



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Occu Health Surgery Center

Respondent Name

New Hampshire Insurance Co

MFDR Tracking Number

M4-25-0548-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

November 4, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 24, 2024	26746	\$11,549.00	\$1,786.84
Total		\$11,549.00	\$1,786.84

Requestor's Position

The requestor did not submit a position statement with this request for MFDR. They did submit a document with the statement, "Please reprocess the attached claim. Please see the attached notes and addendum."

Amount in Dispute: \$11,549.00

Respondent's Position

"This letter acknowledges receipt of your Liberty Health Care Network (HCN) complaint on 11/13/2024. Complaints must be made no later than 90 days after the date of the issue arises that is the basis of the complaint."

Response submitted by: Helmsman Management Services LLC

Findings and Decision

Authority

This medical fee dispute is decided according to [Texas Labor Code §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) 134.402](#) sets out billing and reimbursement guidelines for services rendered in Ambulatory Surgical Center.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
- 983 – Charge for this procedure exceeds Medicare ASC schedule allowance.

Issues

1. Is the insurance carrier's denial based on packaging supported?
2. Is requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of code 26746 – Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, includes internal fixation, when performed, each. The insurance carrier denied this procedure as being bundled into the value of another procedure performed. The following rules apply to the payment of ambulatory surgical services.

DWC Rule 28 TAC §134.402 (d) For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section,

DWC Rule 28 TAC §134.402 (b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise. (6) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and

Medicaid Services (CMS) payment policies specific to Medicare.

Review of the applicable National Correct Coding Initiative Edits as www.cms.gov, does not indicate an edit between code 26746 and 26540. The insurance carrier's denial is not supported. The disputed service will be reviewed per the applicable DWC fee guideline.

The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.2 specifically Ambulatory Surgical Center Services on ASC list. Beginning with the implementation of the 2008 revised payment system, the labor related adjustments to the ASC payment rates are based on the Core-Based Statistical Area (CBSA) methodology. Payment rates for most services are geographically adjusted using the pre-reclassification wage index values that CMS uses to pay non-acute providers. The adjustment for geographic wage variation will be made based on a 50 percent labor related share.

DWC Rule 28 TAC §134.402 (f)(1)(A) states in pertinent part the reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register.

Reimbursement shall be based on the fully implemented payment amount published in the Federal Register. Reimbursement for non-device intensive procedures shall be: The Medicare ASC facility reimbursement amount multiplied by 235 percent;

The following formula was used to calculate the MAR:

Procedure Code 26746 has a payment indicator of A2 as procedure on the ASC list. The following formula was used to calculate the MAR:

- The Medicare ASC reimbursement for code 26746 for applicable date of service is \$1,518.75
- The Medicare ASC reimbursement is divided by 2 = \$759.37
- This number multiplied by the CBSA for Houston, Texas of 1.0026 = \$761.35.
- Add these two together = \$761.35 + \$759.37 = \$1,520.72
- To determine the MAR, multiply the geographically adjusted Medicare ASC reimbursement by the DWC payment adjustment factor of 235% = \$3,573.69
- Review of applicable Addenda AA found code 26746 is subject to the multiple procedure discount. This amount reduced by 50% or \$1,786.84.

2. The DWC finds the MAR for CPT code 26746 is \$1,786.84. This amount is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that New Hampshire Insurance Co must remit to Occu Health Surgery Center \$1,786.84 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February 7, 2025

Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.